



APPLICATION AND CLAIM FOR FUNDS TO DEFRAY BURIAL COSTS TANF RECIPIENTS AND MEDICAID AGED, BLIND AND DISABLED RECIPIENTS

State Form 35937 (R2 / 7-00) / FM 0033

Approved by the State Board of Accounts 2000

INSTRUCTIONS: Claimant shall complete three (3) copies, send two (2) to Local Office of Family and Children, and keep one (1). If claims for both funeral and cemetery expenses are made by one (1) person, only one (1) set of FM 0033 is to be completed. If this is done, the funeral director shall attach a receipted bill showing the amount of cemetery expenses paid by him.

If the funeral claim and cemetery claim are made by two (2) different persons, each shall complete FM 0033 as it pertains to his claim. The Local Office of Family and Children will enter on the reverse side the amount of resources available to meet this claim and after approval the Director certifies that the claim is in proper form, enters the amount approved for payment, signs it, files the original with Financial Management at Central Office.

RECIPIENT INFORMATION					
Name of recipient (last, first, middle):				ICES case number	
Last residence (number and street, city, state, ZIP code):		Check appropriate box TANF MA-A MA-B MA-D 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>		Date of death	
				County number	Name of county
ITEMIZED COST OF BURIAL					
FUNERAL DIRECTOR'S EXPENSES			CEMETERY EXPENSES		
Preparation of body: (includes cremation)			Burial plot:		
Clothing:			Opening & closing:		
Casket:			Wooden box / Concrete slab:		
Funeral services:			Lowering device:		
Transportation:			Tent or artificial grass:		
Professional services:			Vault:		
Other: Specify and attach receipt			Other: Specify and attach receipt		
Total cost of Funeral Director's expenses:		\$	Total cost of cemetery expenses:		\$
CONTRIBUTIONS AND RESOURCES					
	FUNERAL	CEMETERY		FUNERAL	CEMETERY
Insurance			Social Security		
Bank balance			Lump sum death benefit		
Veteran benefit			Other: Specify		
Friends or family					
Total to Funeral Director and / or Cemetery Authority:			\$	\$	
TOTAL CONTRIBUTIONS AND RESOURCES:				\$	
Name of contributor (attach additional pages, if necessary)			Address (number and street, city, state, ZIP code)		
AMOUNT CLAIMED FROM OFFICE OF DIVISION OF FAMILY AND CHILDREN					
Funeral Home or Cemetery			Claim for Funeral Director's Expenses		\$
Address and street			Claim for Cemetery Expenses		\$
City	State	ZIP code			Total \$
PROVIDER CERTIFICATION					
Pursuant to the provisions of Chapter 115, Acts of 1953, I certify that the foregoing account is true and correct, that the amount claimed () is legally due, after allowing all just credits, and that no part of the amount has been paid.					
Funeral Director and / or Cemetery authority signature				Federal ID number	

SUMMARY OF AVAILABLE RESOURCES

Contributions from Relatives and / or Friends:	
Insurance:	
Real Estate:	
Bank Balance:	
Cash on Hand:	
Fraternal Organization:	
Burial Plot: Available w/o Cost:	
Other <i>(Specify)</i> :	
Reimbursement from Social Security Death Benefits ? <input type="checkbox"/> Yes <input type="checkbox"/> No	

ADDITIONAL LOCAL OFFICE COMMENTS

Medicaid effective on: _____	
Name of Local Office Contact Person	Telephone number

COUNTY DIRECTOR'S CERTIFICATION

I hereby certify that the within claim covering burial expenses as indicated is in proper form; that the deceased recipient in whose behalf payment is to be made has been found to be eligible for such services under the provisions of IC 12-14-6, and IC 12-14-17, and that this claim in the amount of _____ is being recommended for payment based upon information submitted to this Office by the Funeral Director and/or Cemetery Authority.	
Signature of Director of Local Office, DFC, FSSA	Date